Cultural Aspects of Health and Illness Behavior in Hospitals

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Health care attitudes reflect the basic world view and values of a culture, such as how we relate to nature, other people, time, being, society versus community, children versus elders and independence versus dependence. Illness behavior determines who is vulnerable to illness and who agrees to become a patient—since only about one third of the ill will see a physician. Cultural values determine how one will behave as a patient and what it means to be ill and especially to be a hospital patient. They affect decisions about a patient's treatment and who makes the decisions. Cultural differences create problems in communication, rapport, physical examination and treatment compliance and follow through. The special meaning of medicines and diet requires particular attention. The perception of physical pain and psychologic distress varies from culture to culture and affects the attitudes and effectiveness of care-givers as much as of patients. Religious beliefs and attitudes about death, which have many cultural variations, are especially relevant to hospital-based treatment. Linguistic and cultural interpreters can be essential; they are more available than realized, though there are pitfalls in their use. Finally, one must recognize that individual characteristics may outweigh the ethnic and that a good caring relationship can compensate for many cultural missteps.

The special attitudes toward illness and treatment reflected in the behavior of members of various ethnic groups tend to be viewed by medical professionals as quaint or peculiar at best or an obstacle to good, efficient, modern medical care at the least. Because cooperation and compliance of a patient and a patient's family are vital to successful treatment, we cannot escape the need to overcome cultural barriers. For that we must increase our awareness of the diverse cultural attitudes about health issues in the ethnic groups we treat and to improve our skills in coping with these characteristics and adapting our treatment approaches to them. We must become aware of our own beliefs, values and attitudes as they affect our care-giving behavior.

Clearly, the cultural approach must be tempered with certain cautions:

- Cultural generalizations, if used in a hostile, condescending way, may not differ significantly from old-fashioned prejudice.
- Certain people, usually the postimmigration generation, *do not like* or are very uncomfortable about being given an ethnic label; they just want "to be treated like everybody else."
- Culture is not restricted to people of color.
- Intragroup individual differences may exceed intergroup differences.
- Our attitudes and blindness to our own tacit assumptions and biases may be more important than those of patients.
- Ultimately, a good caring relationship can overcome any cultural misstep.

Some definitions are in order. *Culture* refers to the sum total of acquired values, beliefs, practices, laws, customs, traditions, artifacts and knowledge possessed and expressed by a designated group, or "all human

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nongenetic, or metabiological, phenomena."[1] *Ethnicity* is that part of our identity derived from membership, usually through birth, in a racial, religious, national or linguistic group or subgroup with its associated culture.

Ethnic diversity contributes to the richness and creativity of society, though too great diversity can also lead to conflict. The healthiest, most dynamic and prosperous societies throughout history have tended to have the greatest ethnic diversity. Each group brings to the larger society the traditional ways of health care —prevention and treatment—acquired over decades or centuries, based on experience and accumulated knowledge. But health care means more than dealing with illness and pain; it reflects the basic world view and values of the culture that in turn influence health and illness behavior.

Cultural Values

Some essential *value orientations* that differentiate cultures[2] and ethnic groups are as follows:

- *The relationship to nature, which may be subjugating, submitting or in harmony with.* The predominant attitude toward nature affects the behavior of a person faced with illness—either actively intervening or passively fatalistic, or sometimes a combination of the two.

- *The view of people as basically good or true.* This outlook will affect one's view of causality, responsibility and hence action to be taken or not taken. Moralistic attitudes toward certain diseases such as alcoholism, acquired immune deficiency syndrome (AIDS), venereal disease, epilepsy and the like reflect such an outlook—that is, that disease is punishment.

- *The preferred or dominant way of interpersonal relating may be vertical, as in authoritarian cultures; horizontal, as in communal cultures; egalitarian and sharing, or individualistic.* Clearly, the preferred style affects decision-making processes between medical professionals and patients, between patient and family and between professionals and family—that is, who makes decisions and how critical issues in health care are decided.

- *Time orientation, whether toward the past, the present or the future, determines action taken or not taken about health matters.* Future-oriented persons will choose prevention (inoculations, prenatal care and so forth), whereas present-oriented persons will not. Present-oriented patients if they are asymptomatic may not take medicine and past-oriented patients may reject new or unfamiliar treatments.

- *A basic orientation with broad health care implications is that of being, doing and being-in-becoming.* A "doing" person will take action, a "being" person may not and a "being-in-becoming" person may do well with prevention, physical fitness, diet and the like, but may not be as activistic as the "doing" person with regard to symptoms.

- *Child versus elder-oriented values affect family priorities, attentiveness, protectiveness about children and elderly and who in the family makes decisions.*

- *Independence versus dependence orientation also contributes to health care behavior.* Independence in our society has often been equated with growth and maturity and psychologic health. Independence is not a developmental stage but a value. In Japanese culture, the ability to depend on others—to lean on others and be leaned on—is considered healthy.[3] The degree to which patients participate in their own treatment—taking or not taking responsibility for decision making or physical care—is determined in part by a patient's dependence or independence. There are obvious sex differences, men more often needing to be taken care of than women. Elderly men are more compliant because they expect to be taken care of. Very independent patients, who may deny their illnesses, can be hazards to themselves. But very dependent and helpless patients can be extremely draining and evoke rejection. This may explain why some alcoholic patients get rejected so often.

- *A global value orientation that has its effect on health care is that of* gemeinschaft *versus* gesellschaft.[4] Gemeinschaft refers to the concept and experience of "community," sometimes romanticized as the village of the "good old days" in which people are primarily involved with people—family and neighbors—and everyone works for survival, but work is otherwise secondary to personal interactions and social pleasures. Gesellschaft refers to "society" in the modern urban sense wherein people are primarily interested in accomplishments and products, whether material, economic, intellectual or creative, and in which personal relations are secondary. For example, a person of rural/peasant background walks off the job on short notice, if any, to go fishing with a cousin. This behavior is unfathomable to those of us from the gesellschaft world, but is not peculiar and may be commendable to those from the gemeinschaft world. In health care, for example, this same patient would view the relationship with a physician as being more important than the treatment. Such a patient might continue with inadequate treatment and not seek another opinion because of a congenial relationship with her or his physician. A gesellschaft patient sees the physician as a technician. Another example is a gemeinschaft patient's decision to neglect symptoms or treatment because of certain ceremonial or festive family obligations or activities, such as a wedding or baptism, or because of culturally designated responsibilities such as to continue being the breadwinner, hence not being able to take time off, and so forth. A gesellschaft person, being more self-oriented than a family/other-oriented gemeinschaft person, may act more quickly and therefore be a "better" patient by our medical standards.

Illness Behavior

Illness behavior refers to the nonbiological—that is, the psychosocial processes that are a product of social

cultural conditioning (values, world view and the like), part of a coping repertoire and a reflection of the meaning and usefulness of the "sick role."[5] Illness is not disease. Persons can have a disease and not feel it or not know or believe they are ill. *Illness behavior determines who is vulnerable to illness.* We will give four examples of illness behavior.

1. *Personality types.* Although psychoanalytic attempts to link personality with vulnerability to physical disease (such as peptic ulcers, neurodermatitis, asthma, irritable bowel syndrome) have been only minimally successful, the type A personality with its association with cardiac disease has been a useful model, and the type C (cancer-prone) personality may prove to be another one. These personality types reflect a behavioral configuration that involves other people, especially family. A person with the type A personality may be someone pulled by the extremes of the gesellschaft-gemeinschaft polarity.

2. *Death dips.* In statistical studies, initially of *Who's Who* biographies, Phillips[6] has shown that prominent people tend to die shortly after their birthdays, rather than before their birthdays, hence the "death dip." The phenomenon also occurs in association with important holidays and is clearly a cultural matter.

3. *Voodoo death.* Ever since Cannon's[7] first article, the phenomenon of death without physical cause following exile or similar rejection in tribal or peasant (gemeinschaft) cultures has fascinated the medical profession. The mechanism may prove to be an adrenocortical overload or autoimmune breakdown phenomenon, but culture (and expectation) is the predisposing factor. For some persons, admission to hospital itself might trigger a poorer outcome than home treatment for similar reasons—that is, the belief that hospitals are for dying.

4. *Social isolation.* Lynch[8] in his *The Broken Heart —The Medical Consequences of Loneliness* and Gunderson and Rahe[9] in their epidemiologic work on life change stress have presented convincing arguments about the connection between ruptured personal relationships—marriage being the foremost—and the subsequent appearance of major disease, especially heart disease. Separated people are the most vulnerable, even more so than the divorced and bereaved.[10]

Illness behavior determines who will agree to become a patient. About two thirds of people who have an illness do not see a physician, hence choosing not to become patients. Although the cultural determinants of patienthood are more evident with psychiatric disorders—some cultural groups will not consider seeing a doctor or any healer for symptoms of depression or alcoholism—even physical symptoms are not exempt from this behavior. Rather than by our medical criteria, persons may choose to be patients on the basis of severity of pain (which also varies with culture), offensive appearance or impairment of certain functions, such as ability to work, bear children, have sexual intercourse or sleep. Some persons may choose to be patients for purposes of rejuvenation, cosmetics, weight loss, ridding oneself (or family and community) of bad spirits or for economic gain (that is, litigation, compensation, maintaining disability status or obtaining sick leave).

Illness behavior determines how one behaves as a patient. As implied above, a patient's behavior will reveal significant culturally determined characteristics. Compliance and cooperation, resistance and rebellion, pessimism and despair, besides reflecting individual personality, will reflect cultural attitudes. What does it mean to be ill? A culture that teaches that illness is a punishment for sin or a curse will produce a different reaction than a culture that emphasizes that to be ill is to be weak, unmasculine or irresponsible. If illness means economic loss or gain, behavior will correspond in obvious ways. These cultural meanings just as importantly will affect a family's behavior, whether the family is supportive, nurturing, attentive or rejecting and avoiding of a patient. In most instances, a rural or peasant (gemeinschaft) family will be more attentive, if not intrusive, than a typical urban cosmopolitan family who leaves the care up to medical professionals. A gemeinschaft family has culturally designated roles and behavior vis-à-vis ill or disabled family members that have been formed over generations. For example, women may have nurturing and nursing roles, but not men. In some languages, for instance, Japanese, there is no name for a male nurse. The primary decision maker and primary caretaker are roles that have been predetermined in many cases, and they usually do not correspond to a cosmopolitan medical system's assignment of roles.

The hospital setting illustrates the culture-based illness behavior most clearly because of the greater seriousness of the situation, the particular structure of hospital organization and roles, needs and responsibilities. First, *culture influences who makes decisions about a patient's treatment.* From the professional viewpoint, by custom and common law, the physician, with a patient's consent, makes the decisions. From a patient's and patient's family's viewpoint, the picture can be very different, depending on the culture. For instance, there are authority figures inside and outside the family. Reaction to these authority figures may depend on the culture's general attitude toward authorities—that is, whether or not it is a vertical system—and depending on the hierarchy of the authority figures. A nontrivial example would be who takes priority, grandmother or American physician, in terms of decision making. For some ethnic groups the primary decision maker may not even be a relative, as is the case, for example, with Gypsy patients.

Authority and responsibility have a complementary relationship, that is, if patients look to another authority for decision making, they will not feel responsible for their own care, nor be expected to be responsible for this care. Because the decision maker may be taken for granted by a patient or patient's family, and because the medical staff may act like they are the de-

cision makers, patients may not reveal who really makes decisions for them in medical matters, so as not to offend the medical staff. Even staff familiar with a particular culture may not help unless asked to do so. When you do not get a clear-cut response about a treatment decision from an Hispanic or Asian patient, he or she may be waiting to first have a consultation with a respected family member. And that person of authority may be the only one who can give a medical history. This also relates to the general matter of which and how many family members may visit a patient. Physicians should remember that the group has a healing function.

Communication in Hospital Settings

The hospital situation highlights special problems of communication with patients of ethnic groups because the hospital experience is so intrusive and so many different professionals and paraprofessionals have access to patients. This is added to the sense of strangeness and high anxiety connected with being in hospital. Why do Soviet immigrants fear being removed or getting out of a hospital bed when other patients are difficult to keep in bed? Etiquette, modesty, touching and spatial distance convey significant nonverbal messages about relationships and traditions that, if violated, can undermine rapport and even disrupt treatment. Most non-American cultures pay great attention to respect and etiquette, probably because of the vertical interpersonal nature of many societies, and the need to establish rules for every interaction. Certain cultures even use different dialects or grammatical forms when communicating up or down the class or caste system. Anglo-Americans tend to be informal and appear rushed if not brusque. This is interpreted as uncivilized, rude and disrespectful. In many parts of the world, one must first sit, chat and have tea or coffee before getting down to business, at least briefly when there is urgency. Paying respect to a family elder may be expected. For example, in the treatment of black children, lack of compliance may be traced to a failure to consult the child's grandmother. Hospitals could serve tea or, if not, hospital personnel could exchange pleasantries with patients and families before plunging into technical examination or care. We should beware of mispronouncing names, especially of patients with tonal languages like the Chinese, Thai or Vietnamese. For example, *ma* can mean mother or horse in Mandarin, depending on the inflection. Mispronunciation does not engender natural trust and respect, and humiliation cannot enhance recovery.

Misuse of terms of address is the most common and the first offense to sensibilities. The inappropriate use of first names before a relationship has been established —except for children—or the use of pseudo-kin terms, such as "auntie," "uncle," "grandma," "pop" and the like, may offend or create discomfort. A rule of thumb is, after exchanging introductions, "Mrs Smith, I am Dr Jones," one should ask "How would you like me to address you?" or "How do you like to be called?" Addressing women patients as "dear" or "honey" is an unpleasant vestige of condescension toward women and an unwarranted intimacy.

Touching a person's body has special meaning and one must know the rules, or at least ask, so as not to upset patient and family and have them lose respect for the examiner and hospital. The most obvious problems involve examination of private parts by the opposite sex, especially among Muslims, some Roman Catholics and Orthodox Jews. But less obvious are concerns in some cultures about the sacredness of the head, which should not be touched casually. If in doubt, ask. Gypsies have especially strong feelings about the separateness of the upper (sacred) and lower (profane) areas of the body. One cannot first take a pedal or femoral pulse and then touch the chest, head or arms. They are very concerned about pollution, and even go so far as not to wear hospital-laundered garments that have been worn by non-Gypsies.

Proxemics is the study of the nonverbal communication expressed by the distance between people.[11] Persons of different cultures tolerate and feel comfortable at different distances, a circumstance that can lead to numerous misunderstandings. For example, Arabs tend to stand and speak very close to each other, within "breathing distance," whereas Americans require a few feet and the British perhaps several more feet between. One can imagine the ballet of an Arab trying to talk with an Englishman who keeps stepping back, the former feeling puzzled and rejected, the latter feeling pressed and pushed upon. The arrangement of furniture may communicate similar cultural traits through the distances between chairs, their mobility, the desk as barrier and the open or closed door.

Verbal Communication Problems

Three verbal communication problems deserve attention. The first is the use of interpreters, whether family members, volunteers or designated employees. Clearly, the use of interpreters compounds the difficulty inherent in cross-cultural communication. Interpreters may distort information because of their own values. For example, a Chinese interpreter would not convey a physician's directive to the Chinese husband of a patient to stop beating his wife because such is the traditional prerogative of a husband in that culture; an interpreter may distort because he or she has a wish to impress the physician, or not to embarrass the physician (or nurse), or to make a situation appear less serious, or because the interpreter does not consider some of the information significant, and so forth. If a patient is expressing delusions or describing hallucinations, an interpreter may, with slight alteration, make these symptoms sound rational, so as to make sense out of them. In cross-cultural work one must match eccentric thoughts and behavior against the prevailing standards and beliefs of that culture. For instance, seeing spirits and ghosts may not equate with visual hallucinations per se in a culture in which such experiences are common.

A second problem may involve English as a second

language, whether the patient's or the physician's. Even non-American English speakers may be misunderstood. For example, after a hearty meal, an American might say "I feel stuffed," which to a Briton colloquially means to have had sexual intercourse! But the linguistic issues go beyond misunderstanding words, which occurs even between generations (such as "Valley girls' " or musicians' hip patois). These involve the distorting effects of unusual inflections and syntax. The resultant problems often are more emotional than cognitive. Filipinos may sound evasive and insincere; South Asians or Indians may sound "pushy." The consequences, even in the medical realm, have been very serious accusations and poorly understood (or not believed) defenses against medical negligence. Anthropology Professor John Gumperz of the University of California at Berkeley has studied and testified in such situations. There is also an excellent film, "Crosstalk,"[12] that illustrates some of these problems.

A third verbal problem is the magical meaning of words. Even sophisticated people sometimes act as though naming a disease will cause it. Hence, there may be a reluctance to raise questions about cancer, alcoholism, suicide or other taboo diagnoses or possibilities—such as skin diseases or Hansen's disease in some (tropical) cultures. Some Hispanic and rural persons may not dare tell their physician what is really bothering them for fear of the magical effect of naming. We also need to be cautious about being blunt in order not to precipitate panic.

An extreme communication problem is when there is none at all, such as the case of a Cambodian boy with an acute appendicitis who was rushed to emergency and to the operating room of a California hospital without the benefit of explanation in the absence of an interpreter. The medical staff was oblivious to the fact that the boy was expecting to be executed by evisceration, a common form of execution by the Khmer Rouge in his recent past. That he did not die from voodoo death was a miracle in itself.

Diet and Medication

Cultural practices may impede or even negate cosmopolitan medical care. This is especially true with compliance with diet and medication. Dietary practices are probably the most unshakable learned behavior, and food has great symbolic importance. But culturally relevant and acceptable diet is easy to arrange and often cost effective. Unacceptable foreign food is very demoralizing and could logically inspire a patient to question the relevance of the medical treatment itself and the competence of medical staff. Contributing to attitudes toward diet and medicines is the hot-cold concept derived from Hippocratic humoral medicine and spread throughout the world by Arabic influence and later, in turn, Spanish colonialism.[13-15] Although the current forms of this system vary by geographic region and national boundary and basically have no physiologic or nutritional basis for the determination of which substance (or disease) is labeled hot or cold (including drugs as well as foods), the concept of balance involved can be used constructively. We can adapt, for the sake of gaining compliance, our prescriptions and dietary orders to the hot-cold system by serving medicines either in or with acceptable foods or beverages. For example, some cultures consider penicillin a "hot" substance and therefore will refuse an injection in case of a fever, but orange juice is a cold food. Penicillin given in orange juice might be acceptable. A baby with dysentery (a cool disease in Guatemala) may be denied water because the water is considered a "cold" substance, and sick babies need to be kept warm. In other words, prescribing and walking away is not enough. It is necessary to determine whether or not a prescription will be implemented. The concept of balance and neutralization, however, can be used to explain our treatments and obtain cooperation from a patient and family.

Other possible blocks to compliance can be postpartum and menstrual taboos whereby a culture prescribes what may or may not be taken into the body or put on the body at those times. A postpartum woman in some areas of the world needs to be kept hot (even in the tropics) and therefore cannot eat fish (the most available source of protein and considered "cold"). One of us (J.H.) had an Hispanic patient with depression who after several months of lack of response to antidepressants indicated that she did not take the medication for about ten days during and after her menses. Another problem with compliance occurs with medication given prophylactically or on a long-term basis when no symptoms are evident, such as for tuberculosis or epilepsy. These situations are just extensions of the problems also seen with educated and sophisticated patients.

Cultural Differences and Pain

Regardless of illness and health beliefs, the central symptoms for which all people seek help is pain. But, the perception and experience of physical pain and psychologic distress vary among cultures and the physical and psychologic distress varies independently. Our perception of pain or distress colors our inferences and empathy or sympathy toward the experience in others. Not only does the experience of pain and distress vary, but the readiness to complain varies culturally. Furthermore, we have prejudices about how others experience and react to pain that alter our sensitivities. In some cultures complaints are rewarded with attention, affection and comforting behavior, which probably reinforces that style of reaction. American Jewish and Italian parents have been noted to be especially indulgent and attentive to their children regarding pain, perhaps thereby encouraging sensitivity to pain.[16] Other cultures reward stoicism or punish complaining children, resulting in adults who may actually feel less pain. But the interaction between the learning and genetics of pain sensitivity has still to be delineated. An excellent study of the cultural issue was done by Davitz and Davitz in their *Inferences of Patients' Pain*

and Psychological Distress—Studies of Nursing Behaviors,[17] in which the attitudes of 4,000 nurses from 13 countries were compared. We will summarize some of the findings by presenting the polarities:

- Nurses generally see patients of lower socioeconomic status as suffering more (except for cardiac patients) than patients of higher socioeconomic status; women suffer more than men, but women of high socioeconomic status suffer the least. (Note the role of identification with persons of one's own socioeconomic status.)
- Nurses tend to infer a greater degree of psychologic distress than of physical pain in evaluating patient suffering.
- Nurses see Jewish and Hispanic patients as suffering most, Asian and Anglo-Saxon/Germanic patients as suffering the least and other ethnic groups falling between.
- Black nurses tend to infer a greater degree of psychologic distress than white nurses, regardless of patients' race.
- Nurses of northern European background inferred the least painful suffering in patients. Nurses of African and south and east European backgrounds inferred relatively high patient suffering (each group may be projecting its own experience of pain).
- Nurses from Asian countries showed a great range of national differences in inferring psychologic distress and physical pain, Koreans inferring the most of both and Japanese next, whereas Taiwanese and Nepalese inferred the least psychologic distress, and Thais were intermediate; Thai nurses inferred the least physical pain, with Taiwanese, Nepalese and Japanese inferring more physical pain, increasing in that order. The diversity certainly shows how difficult it is to generalize on the basis of race.
- Puerto Rican nurses inferred psychologic distress to be very high and physical pain to be very low. (They explained this in terms of discounting some of the pain complaints because of the "emotionality" of their countrymen.)
- Jewish Israeli nurses inferred relatively low psychologic distress and physical pain—differing markedly from non-Jewish American nurses' views of Jewish patients, again highlighting cultural over racial (genetic) factors.
- English, American and Belgian nurses expressed the lowest inference of physical pain. (I recall my clerkship at Guys Hospital in London when a distinguished professor made the point that if he were in pain he would prefer to suffer and think clearly so he could read his favorite books rather than take opiates.)

This last finding has wider implications because American nurses have contact with and serve people from many different backgrounds and different ways of expressing feelings, a reflection of the heterogeneous American population. There is every reason to believe that what is true for nurses is true for physicians. If a nurse (or physician) infers less pain or distress than a patient complains of, the patient is labeled a complainer, evoking anger, irritation and rejection by the nurse (or physician), or at least lack of support. This no doubt contributes to a patient's demoralization and possibly delayed recovery and a vicious cycle of more complaints and demands and more rebuffs. The opposite might occur if a nurse infers too much pain or distress. In that case a patient (and family) might develop excessive anxiety and apprehension. There is an optimal amount of anxiety,[18] and rejection and hopelessness are never helpful or health-inducing.

Religious Beliefs

Regarding hope, let us briefly discuss religion. Religious beliefs and practices are part of culture, yet our American society behaves ambivalently toward religion. We fluctuate between secular life-styles and values and periodic religious fervor and even fanatic bigotry. But there are people for whom religion is a daily presence, a high proportion of whom may be among the so-called ethnic minorities. For these people, being in hospital should not mean that their religion must be excluded. In fact, prayer to one's God gives comfort and hope and may be lifesaving. Religious articles and symbols, even amulets, are important and need to be treated with respect and sometimes encouraged. Even a secular physician or nurse has her or his amulets, such as titles, white uniforms, dangling stethoscopes and the like. Respect is an issue, even for those who do not want religion imposed on them. For Muslims (and Orthodox Jews), bovine, not porcine, insulin must be given, though rules for Jews can be suspended to save a life. It should be remembered that the largest Muslim populations are not in the Middle East but in Indonesia, Malaysia, Pakistan and Bangladesh. We may say, "Well, how would the patient know?" (that he or she received porcine insulin); the response might be, "If he knew it might kill him," because honesty, trust and ethics are major components of the healing relationship.

Last, as ever, comes death. Anglo-Saxons' and northern Europeans' reactions to death tend to be restrained, except perhaps for the Irish at a wake, whereas many other cultures encourage and even require great demonstrations of feelings. Similar differences exist regarding the handling of the deceased, the farewells, the preparations for burial and the question of autopsy. Anticipatory plans for death, even asking an appropriate religious figure to come to see a patient, may be considered by some Middle Eastern people extremely bad taste and an indication of not trying to save the life. It is advisable to deal with a family through an intermediary such as a distant relative, if possible, to determine what the family wants and expects.

Conclusion

Obviously the complexities of many cultures are such that one cannot master any but one's own. But an

approach can be developed. Like the psychotherapist, we can all ask, "What do you mean by that?" A genuine interest, a willingness to give a little extra and a respect for customs can go a long way toward improved communication and compliance, and thus a better outcome. We should ask about customs and practices, listen, explain and correct for our own cultural biases (for instance, regarding pain tolerance), use intermediaries and interpreters, colleagues and other hospital staff and be aware of the possible distortions in transmission. But, as stated above, a good caring relationship is still the greatest insurance against, and antidote for, the inevitable cultural mistakes.

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